Arkansas Abstract

The Arkansas Money Follows the Person application will transition 305 individuals who have resided in institutions six months or longer into qualified home and community-based programs. The following populations residing in nursing homes and ICF-MRs will be served: Individuals with developmental disabilities/mental retardation; individuals with mental illness; individuals 19 to 64 with physical disabilities; and individuals age 65+.

The application is submitted by the state Medicaid agency, the Division of Medical Services in partnership with the Divisions of Aging and Adult Services, Behavioral Health and Developmental Disabilities. All Divisions are part of the Arkansas Department of Health and Human Services and serve under the same Department Deputy Director

Arkansas previously obtained four years of nursing home Minimum Data Set (MDS) data which it used to help identify the number of individuals that might transition to the community, what services they might need and where potential candidates reside. Consumers, AARP, Area Agencies on Aging, Independent Living Centers and the Governors Integrated Services Taskforce and others were active in the development of the application and are committed to serving individuals in the community.

The largest number of individuals that transition to the community will do so through ARHome a new 1915(a)(c) waiver that gives consumers in nursing homes the opportunity to return to the community by directing their own care, receiving care from agencies or a combination of the two. ARHome is built on the State's 1115 Demonstration waiver, IndependentChoices which was an original US HHS and Robert Wood Johnson Foundation Cash and Counseling program state.

Consumers may also transition to the community through one of three existing waivers that serve individuals with developmental disabilities, the aged and adults with physical disabilities.

Recognizing that individuals who have resided in institutions for longer than six months may require more services than current waivers and state plan options allow, the state will offer the following HCB Demonstration services for one year to each person transitioning: Telemedicine; a 24 Hour Helpline, Intensive Transition Assistance and Attendants to accompany them when using the states medical transportation system.

Based on stakeholder input during the MFP grant development, the State will develop a Traumatic Brain Injury (TBI) waiver to help transition individuals with TBI.

A total of $21,463,461 is requested: $19,987,485 for Qualified HCB Services, $2,311,092 for HCB Demonstration Services and $1,475,976 for administrative costs.

STATE OF WASHINGTON – ROADS TO INDEPENDENCE

PROJECT ABSTRACT

Washington State is among the nation's leaders in responding to consumer demands to live independently in their own communities. The state has accomplished this by rebalancing its continuum of services to make community living a priority. Attention to consumer choice and self-direction, careful assessment and referral mechanisms and varied and accessible supportive services are the hallmarks of the Washington State system. In 1991 approximately 80% of the state's caseload was served in institutional settings. In a striking turnaround, 76% of individuals currently receiving Medicaid long-term care services and 97% of persons with a developmental disability are accessing care in their own homes or in community-based settings.

Over the past 20 years, the state's rebalancing efforts have resulted in a steady decline in institutional beds. In 2006, the state is seeing this trend level off for the first time. That, coupled with the increased incidence of disabilities and other demographic trends, creates an urgent need to develop additional rebalancing strategies. The Money Follows the Person Rebalancing Demonstration offers a timely and important opportunity to address the growing complexity of the rebalancing efforts of the Washington State long-term care system.

Washington State's demonstration, entitled "Roads to Independence," builds upon our experience designing successful community-based service systems. Washington State requests $27 million in state and federal funds over a 5-year period to transition 660 high-acuity individuals whose needs exceed services and supports offered under current programs. Our vision for this demonstration project is to support individuals who choose to move from institutional settings to achieve their goal of independence. Participants and family members, providers, and institutional representatives are central in the planning implementation and monitoring of the demonstration. Target groups for this project include older adults, individuals with developmental disabilities, individuals with physical disabilities, and individuals with mental illness. The project strategies include:

- Fortify the culture of respect for self-direction by providing education at all system levels.
- Identify long term residents of institutions who want to move to the community.
- Expand person centered planning to all participants.
- Create intensive transition supports starting before discharge and continuing into the community. Identify and planning for housing, medical, transportation and social supports.
- Develop and train peer specialists, educators and mentors to provide outreach and resource development for individuals in institutional settings.
- Partner with Vocational Rehabilitation to develop employment strategies for participants.
- Purchase one-time supports to facilitate successful transitions, such as assistive technology and service animals.
- Employ quality management measures and outcomes to ensure accountability, cost-effectiveness, and participant success
- Adjust existing waivers and Medicaid State Plan services to assure continued support beyond the first year for demonstration participants
- Partner with the Housing Trust Fund, local Housing Authorities, Vocational Rehabilitation, Mental Health, the Developmental Disabilities Council, Tribal Nations, Area Agencies on Aging, the aging network, and other consumer advocacy groups in project design and implementation.

ABSTRACT

The state of Texas proposes to continue rebalancing its long-term services and support system so individuals have more choices in determining where they live and the services they receive. Texas plans to enhance its Money Follows the Person (MFP) and Promoting Independence Priority Population initiatives by assisting individuals living in institutions to live in the place of their choice.

For individuals in nursing facilities, Texas: 1) will build upon its current MFP Initiative and use the enhanced match to finance home and community-based services and improve outreach efforts; and 2) will target for transition individuals with complex support needs in general and through a new pilot focused on individuals with co-occurring behavioral health conditions. For individuals in institutions serving persons with intellectual and developmental disabilities, Texas: 1) will build upon its current initiative and use the enhanced match to transition individuals out of 14-plus bed community-operated intermediate care facilities and State Mental Retardation Facilities; and 2) will implement a new initiative to close nine-plus bed community-operated intermediate care facilities and transition residents to other settings of their choice, including community waiver programs.

Texas will use grant funds for enhanced match to provide home and community-based services to more individuals and to invest more funds in transition processes. Texas will use this grant to help transition 2,616 Texans over the next five years, of which 1,400 will transition from nursing facilities and 1,216 will transition from facilities serving persons with intellectual and developmental disabilities. The total budget for this project is $179,464,601. Texas will request $17,846,249 in enhanced federal matching funds.

ABSTRACT

The State of South Carolina is applying for this demonstration grant to target elderly and/or physically disabled adults that would be eligible and prefer to transition from institutional care to home and community-based care. The State previously was awarded a nursing home transition grant and over the course of three and a half years, transitioned a total of 90 consumers. Additionally, the State has received three other Real Choice grants that have been used to build and modify its long term care infrastructure. This grant would allow the State to build on its past success transitioning individuals to home and community-based care.

The State is proposing to utilize services found in the *Community Choices* waiver as its base of support in the home and community setting. In addition, two demonstration services, adult foster care and transition nursing services, will be added. It is believed the adult foster care service will help address residential issues that sometimes impede individuals from accessing home and community-based services. The transition nursing service will be utilized to help train and educate both families and the consumers returning to the community from a nursing facility. Finally, the State is proposing to add one supplemental demonstration service: Adaptive Devices. The State believes this one-time service will help individuals modify their environment so that they are able to make a smooth transition to home and community-based care. The request is for a four year demonstration period preceded by a nine month pre-implementation phase during which time the State will engage in formal planning and development. This planning will involve needed stakeholders in developing the operational changes necessary to perform the grant.

Abstract

W. Edwards Deming, the guru of quality service said, "What we need to do is learn to work in the system, by which I mean that everybody, every team, every platform, every division, every component is there not for individual competitive profit or recognition, but for contribution to the system as a whole on a win-win basis." Led by support of the governor and key executive and legislative leaders, this project has brought together a wide range of state agency and community organization leaders, and stakeholders in developing the Opportunities for Living Life Advisory Council () and Money Follows the Person Committee to oversee the design, development and deployment of the Oklahoma Long-Term Living Choice Project. Each partner in this project agreed that the goal was not to benefit any one agency, but to generate funds that would benefit citizens through out Oklahoma. Further, each partner provided direct writing, technical assistance, or verbal input for the components of this project which are focused on transitioning to provide a better balance of Oklahoma's long-term care system.

Throughout this document Oklahoma addresses barriers to community living and proposed transitional reform through innovative pilot projects designed to be fully implemented at the end of the five year grant cycle. The Total Annual Budget request of $52,241,801 will allow expansion of ongoing projects, and improvement of community integrated services by bringing agencies and organizations into a continuous collaborative framework to collectively achieve the goals designed to:

- Increase the use of home and community-based, rather than institutional services
- Eliminate barriers that prevent or restrict the flexible use of Medicaid funds
- Increase Choice and Control for the Self Directed Service Delivery System
- Assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting
- Provide for continuous quality assurance and quality improvement of services for those receiving Medicaid home and community-based long-term care services
- Long-term Supports Coordinated with Affordable and Accessible Housing

Ultimately, OLLAC will have developed a seamless infrastructure that readily affords individuals the opportunity to elect appropriate medical and social services in an environment of their choosing; thus, increasing the use of home and community-based, rather than institutional, long-term care services. Moreover, state agencies and community partners will have developed a paradigm wherein communication is effective, resources are shared, and care is person centered.

The application represents a collaborative partnership among the Oklahoma Health Care Authority, Oklahoma Department of Human Services, Aging Services Division (DHS), Development Disabilities Services Division (DHS), Oklahoma Department of Health, Oklahoma Department of Mental Health and Substance Abuse, Oklahoma Development Disabilities Council, Oklahoma City Housing Authority, Oklahoma Finance Agency, Oklahoma State University – Oklahoma City, University of Oklahoma Health Sciences Center, Oklahoma Statewide Independent Living Council, Progressive Independence, NAMI Oklahoma, Areawide

Aging Agency, Long-Term Care Authority (Tulsa), and the Olmstead Committee. The outcome, once funded, means true systemic reform.

Ohio MFP Demonstration – CFDA 93.779

Project Abstract

Ohio proposes a five-year MFP Rebalancing Demonstration to transition approximately 2,200 elders and people of all ages with disabilities from institutions to home and community based (HCB) alternatives. Ohio's MFP project will operate statewide to identify and serve Medicaid consumers with different care needs, but who have in common a minimum six month institutional length of stay, and the desire and capability to move from institutional to HCB settings with the right services and supports.

Ohio's MFP project will invigorate public and legislative debate regarding the right balance of Medicaid resources between institutional care and HCBS, and will examine the preadmission screening function for institutional entry. MFP will build on existing Medicaid HCBS waivers, state plan services and delivery systems, adding capacity and a coordinating "hub" for MFP participants. Ohio proposes to add HCB Demonstration and Supplemental Demonstration Services to facilitate a successful transition from institution to community. Examples include: independent living skills, peer support, benefits coordination, housing locator, service animals and home computers. Demonstration services will be phased out as people can be sustained through an HCBS waiver, Medicaid state plan, and other non-Medicaid services such as rent subsidies, food stamps, SSI/SSDI, etc. Ohio's MFP project will maintain and further expand opportunities for consumer directed care.

ODJFS, Ohio's single state Medicaid agency, will work in collaboration with Sister State Agencies, County MR/DD and behavioral health authorities, Area Agencies on Aging, institutional and HCB service providers, consumers, and a variety of advocacy organizations in the design, implementation and oversight of Ohio's MFP project.

Ohio's preliminary budget for the five-year MFP project is estimated to be $65 million (state share) and $157.9 million (federal share) for Qualified HCBS, HCB Demonstration, and Supplemental Demonstration Services and $25.8 million for administrative activities (all funds).

Project Abstract and Profile

In its role as the single state Medicaid agency and consistent with CMS' clear direction to MFP demonstration applicants, the New York State Department of Health (DOH) enlisted the support of a Workgroup comprised of consumers, consumer controlled organizations and sister state agencies, to assist in the design of New York's MFP proposal. The Department and the Workgroup have worked collegially in the development of the MFP application, particularly with respect to identifying barriers to transitioning individuals from institutional to community based settings and proposing potential solutions to overcoming those barriers in the context of the MFP demonstration.

The State expects to begin implementation of its MFP demonstration in January 2008. During the MFP demonstration, the State will serve individuals with disabilities, ages eighteen (18) or older and seniors, individuals who have resided in a nursing facility for at least six months. Given the above eligibility criteria, the State will serve multiple population groups including individuals with mental retardation and developmental disabilities and individuals with mental health disabilities. New York State seeks funding for covering the entire period of the demonstration, with the first 12 months devoted to Pre-Implementation activities. It is projected that a total of 2,800 individuals will be transitioned over the demonstration period. The total MFP funding requested is $82,636,864, of which $27,200,000 represents enhanced FMAP dollars.

ABSTRACT: "NEW HAMPSIRE MONEY FOLLOWS THE PERSON"

As a natural extension of its participation and success in implementing a variety of Real Choice Systems Change initiatives, New Hampshire intends to continue its efforts to transform the community based system of support for all residents through the implementation of the **NH Money Follows the Person (NH MFP)** initiative across the state. NH will utilize the options created under the Deficit Reduction Act (DRA) of 2005 to further its efforts to rebalance its community-based long-term support programs that allow Medicaid programs to be more sustainable while helping individuals achieve independence. In collaboration with stakeholders, NH will work towards reducing its reliance on institutional care while developing community-based long-term care opportunities, enabling older adults and those with disabilities to fully participate in their communities, consistent with the direction of both federal and state policy.

Specifically, New Hampshire will work to:

- Rebalance the long-term support system to provide individuals with greater choice of where they live and receive services;
- Transition eligible individuals from institutions to appropriate community settings; and
- Further NH's strategic approach to implementing a system that provides person centered, appropriate, needs based, quality services and supports that ensures a high level of access and quality in both home and community based settings and institutions.

NH MFP will be open to all persons who have resided in a qualified institution for a minimum of six months and who express an interest to move into the community. This includes, but is not limited to; adults and children with mental illness, acquired brain disorders, developmental disabilities, Alzheimer's disease/dementia, chronic health conditions, and physical disabilities. NH MFP will be available statewide but will be implemented in two phases beginning with the Southern, more populated regions of the state.

This proposal reflects a major shift in Medicaid policy from its historical emphasis on institutional long-term care to a system that offers greater choice for participants. The initiative will take the "lessons learned" from NH's previous nursing facility transition grants and expand the model statewide. In year one, four outreach coordinators will be hired and located in key community sites to identify interested participants. These coordinators will work with participants through the transition process to assist them in securing the necessary services and supports to successfully transition back to the community. Ongoing coordination and provision of services and supports will be provided through community agencies following transition.

Under Money Follows the Person, NH will be eligible for Medicaid reimbursement at an enhanced federal match rate of 75% for all qualified home and community based services for one year. This enhanced match rate will assist NH in its ongoing efforts to increase the capacity for the provision of home and community based services. NH proposes to transition 10 persons in year one of the demonstration and 90 persons in each year thereafter. The demonstration is proposed to last for five years, at which time it is expected that the community based infrastructure will be adequate to support all residents who choose to live in the community rather than be admitted to an institutional setting. The demonstration is requesting a total of $16,323,827 over the five year period; $11,609,257 federal funds, $2,931,228 state funds, and $1,783,342 county funds.

State of Nebraska's **Transition: Deal or No Deal**
Money Follows the Person Demonstration Grant

Project Abstract

The State's goal for this engagement is to support the choice of 900 people (aged, physically disabled, developmentally disabled, traumatic brain injury) to move from nursing homes and ICFs/MR to community settings. This is approximately ten percent of the current population in those institutions.

The total estimated budget for this program is $75,496,358

The State's mission will allow these individuals to:

- Live in home and community settings based on their needed supports and preferences
- Exercise meaningful choices about their living environment, providers of services they receive, types of supports they use, and the manner by which services are provided
- Obtain quality services in a manner as consistent as possible with their community living preferences and priorities

The State will build upon its existing home- and community-based waivers for the target populations, using the first year to plan for implementation. The State plans to "fast-track" transition for individuals who can thrive within the existing services, i.e., without enhancements or waiver amendments or capacity building. As the State is conducting this first fast-track transition phase, the State will enhance its community service system to support the second "wave" of individuals as they transition into the community.

The State will use the grant to achieve the following systems change outcomes and products:

- To increase capacity for supports and services needed in the community
- To increase access to behavioral health supports in the community
- To invest in remote technology to support assessments, interventions and monitoring/ supervision, where appropriate and cost-effective
- To invest in a "transition planning" capability that enhances the support for informed choice, risk assessment and mitigation, reconnection with communities, and sustained success in the community beyond what is currently available in services coordination. Investment will occur through the design of a new targeted case management level and rate, as well as funding for five new positions at the State.
- To design a "rural solution" that creates an appropriate, multi-faceted and flexible array of supports and services in selected areas that support the choice of people who seek to live in rural or frontier communities.
- To develop a consumer-centric "no wrong door" access portal that responds to the presenting issues of the elderly or individuals with disabilities, which will create the conceptual platform for more streamlined and consumer-friendly access, assessments and eligibility determinations.

State of Missouri: Money Follows the Person Rebalancing Demonstration

Project Abstract

The overall goal of this initiative is ***"to support Missouri citizens who have disabilities and those who are aging to transition from institutional to quality community settings that are consistent with their individual support needs and preferences".*** This initiative will enhance existing efforts to transform the long-term support system that provides services for people with disabilities and will result in an increased use of home and community-based, rather than institutional, long-term care services. As a result of this five year demonstration the state will:

Objective #1: Transition a minimum of 250 individuals who have disabilities and those who are aging who choose to move to the community from state Habilitation Centers and Nursing Facilities to the community. This demonstration will include participants with significant developmental and psychiatric disabilities living in state Habilitation Centers and individuals with significant physical and aging related disabilities living in Nursing Facilities. Individuals who choose to participate will receive support and assistance to plan their transitions and to access needed community services (e.g. housing, medical care). Following the demonstration, participants will receive ongoing community services and supports (e.g. waivers, state plan services).

Objective #2: Eliminate barriers that prevent individuals currently residing in state institutions from accessing needed long-term community support services. This demonstration will improve access to a variety of important transition services (e.g. person centered planning, transition support funds) and community services (e.g. mental health services for individuals who experience co-occurring developmental and psychiatric disabilities).

Objective #3: Improve the ability of the Missouri Medicaid program to continue provision of home and community based long-term care services to individuals who choose to transition from institutional to community settings following this demonstration. This demonstration will address existing barriers to money following the person from institutional to community settings to fund needed community supports and increase opportunities for individuals to self-direct their community services and supports.

Objective #4: Ensure that procedures are in place to provide for continuous quality improvement in long-term care services. This demonstration will facilitate collaborations with existing state system transformation efforts designed to enhance integrated Quality Management systems that support consumer choice, consumer satisfaction, and positive systems changes.

This project will be accomplished through partnerships with multiple stakeholders that include individuals with disabilities and their families, state agencies, legislators, community providers, consumer advocacy groups, the University of Missouri, and others. The Missouri Department of Social Services Division of Medical Services, the single state agency responsible for the administration of Missouri's Medicaid Program, will have overall responsibility for administration of this project in partnership with the Missouri Department of Mental Health (Divisions of Mental Retardation/Developmental Disabilities and Comprehensive Psychiatric Services) and the Missouri Department of Health and Senior Services. The ongoing collaboration and participation of these multiple stakeholders in the design and implementation of this project will be supported through the Missouri Personal Independence Commission which is charged with advising the Governor on necessary policy and program changes to assure that Missourians of all ages and disabilities have access to needed community support services.

Total Five Year Budget: $22,223,795

Money Follows the Person Rebalancing Demonstration

ABSTRACT

The grant will contribute to Michigan's rebalancing efforts and the direction set by the Governor's Medicaid Long-Term Care Task Force. The proposal reflects the priorities of the Task Force and benefited from input from the full range of stakeholders, including consumers, advocates, nursing facility providers and community-based service providers. The project will serve individuals who are elderly or have physical disabilities. Individuals will receive community services from either the MI Choice waiver for elderly and people with disabilities or the Home Help state plan personal care program, with transition services provided by the Single Point of Entry program, the MI Choice waiver program or Centers for Independent Living. The grant will be administered by the Medical Services Administration within the Michigan Department of Community Health, in cooperation with the Office of Long-Term Care Supports and Services.

The grant will produce an operational protocol for transition services. This will be the product of collaboration between the state Medicaid program, the Office of Long-Term Care Supports and Services, the Office of Services to the Aging, the Commission on Long-Term Care Supports and Services, the Michigan State Housing Development Authority, the State Ombudsman Office, the Michigan Disability Rights Coalition, the Disability Network/Michigan, consumers and advocates, nursing facility provides, and community service providers.

The goals of the project are to (1) assist at least 3,100 individuals in transitioning from nursing facilities or hospitals to their homes or qualified community residences, (2) develop and provide housing coordination services to individuals transitioning to the community, (3) develop within the MI Choice waiver for elderly and disabled the option of receiving services in licensed settings, allowing for the transition of at least 600 individuals (of the 3,100 total) to qualified residential settings. The project will participate in the national evaluation and produce analyses of the fiscal impact, the systems impact and the impact on the lives of individuals who transition to the community.

The work of the project will be integrated into current initiatives designed to transform Michigan's long-term care system. These initiatives include the 2005 addition of transition services to the MI Choice waiver, the 2006 addition of self-direction options within the waiver, the 2006 initiation of a Single Point of Entry Program and the development of a demonstration program for a prepaid, capitated model of long-term care services.

The proposed budget requests $67,834,345 in federal funds.

Abstract

The State of Maryland proposes to implement a Money Follows the Person Demonstration Program statewide, beginning July 1, 2007 through December 31, 2011 for eligible persons who express a desire to transition to qualified community residences from nursing facilities (NF), intermediate care facilities for the mentally retarded (ICF/MR), chronic care hospitals, and public institutions for mental diseases (IMD). The State is committed to transitioning a total of 5,832 individuals during the demonstration period, and is estimating that half, or 2,916, of these individuals will be eligible demonstration participants.

The State proposes to implement an aggressive identification and transition assistance program throughout the State from day one of implementation, using transition teams of professionals as well as peer counselors who have experienced institutionalization themselves to canvass facilities and identify potential individuals for transition to the community. Transition services will include, in addition to aggressive, comprehensive outreach, increased efforts to make community-based options information available to persons living in institutions, identification and follow-through with individuals expressing a desire to transition, assistance with eligibility determination process for community-based services, assistance with identifying and securing affordable and accessible housing, help with establishing a household, assistance in securing home- and community-based (HCB) services and providers as well as non-Medicaid services (food stamps, etc.), peer-counseling and mentoring prior to and after transitions, and an evaluation of nutritional needs and coordination with nutrition services.

Demonstration participants will receive a full-range of qualified HCB services and HCB demonstration, aligning with the rich service packages of existing HCB waivers to ensure that all demonstration participants will have equal access to the full range of services. In addition, the State is proposing to include supplemental non-Medicaid demonstration services, such as housing subsidies and non-Medicaid transportation services. Thus, in sum, each participant will have available a comprehensive set of services from the moment they decide they want to transition, through to a full set of supports and services. The State intends that the transition services will be "one-time-only" in nature, in that by the end of each participant's 12-month participation, the transition services will no longer be required. All participants will seamlessly transition to waiver services at the conclusion of their demonstration participation period.

The State engaged in an extensive process to gather, listen to, and incorporate stakeholder (including provider) concerns and recommendations. The State conducted two large public meetings and conducted focus groups in six institutions, and then shared two drafts of the narrative portions of the application and responded further to comments. The State is committed to the continued direct, vital participation of the stakeholder and provider communities in the implementation and decisions surrounding Maryland's Money Follows the Person demonstration program.

Project Abstract and Profile

Goals

Indiana proposes to strengthen and expand institutional transition activities through access to the Money Follows the Person demonstration grant. Indiana is engaged in a number of initiatives designed to increase access to HCBS, including a NF closure and conversion program, a NF diversion program, closure of the State developmental centers and transition of self-referred NF residents. Indiana's goals specific to the demonstration include: proactively identify NF residents (elders, adults with physical disabilities, including TBI, and adults with MR/DD) who have been institutionalized for at least six months who have expressed a desire to move to small community-based settings;, provide comprehensive options counseling to these residents, facilitating informed choice regarding their options for alternative LTC; facilitate and ensure safe transition to a qualified community setting; ensure access to these settings, including adult foster care homes, residential habilitation homes, family or independent homes and access to other necessary supports and services; ensure follow up throughout the first year of adjustment to the new setting; track and evaluate outcomes for these individuals; and use this outcome-based data to refine Indiana's ongoing transition efforts. FSSA has set a long-term goal of rebalancing the LTC system through the combined efforts specific to all institutional diversion and transition activities to achieve a more equitable balance between institutional and HCBS options.

Total Budget

Indiana is proposing a budget (Federal share) of: $21,593,916 for the demonstration, comprised of: $18,599,258 for 12 months of qualified HCBS per participant provided between 2007 and 2011, $ 629,981 for demonstration services and $2,364,637 for administration (of which $1,847, 857 is for transition team expenses and $162,847 for staffing of the project including $52535 for the full-time project director.

Grant Fund Use

Funds will be used to support a strengthened stakeholder input process; help develop and improve transition team training materials and processes; develop options counseling materials and processes to increase personal choice; implement an improved assessment process for home care; and develop and implement person centered planning. The integration and coordination of services and supports across programs including HCBS waivers, Medicaid state plan services, OAA services, CHOICE state-funded services, etc. will be improved through improved IT system integration. Funds will also support the work of the full-time project director who will participate in system change activities, emphasizing the specific needs of demonstration participants including the transition process, the development of community capacity, especially small, residential options like apartments and adult foster care settings, accessible transportation, home care and meals and improvement of the quality oversight and improvement processes.

Ultimate Outcomes and Products

Indiana seeks to develop a more mature transition program that formalizes identification of individuals residing in NFs who have expressed a desire to move to community-based settings and, to the extent desired by the individual, facilitates their successful transitions to small, community-based settings. Successful targeting, a reliable assessment tool, and a person-centered planning and follow along process that is clinically guided will guide this process. Indiana anticipates transitioning 1,039 individuals as a result of access to this grant.

Iowa's Partnership for Community Integration
Abstract

Iowa's *Partnership for Community Integration* (MFP) demonstration project will significantly improve the opportunities for individuals diagnosed with MR/DD or related conditions to receive the supports and services needed to sustain them in community settings. The project builds on the work Iowa Medicaid Enterprise (IME) began with their 2005 Real Choice Systems Transformation grant to enhance access to home and community-based (HCB) services. In applying for this grant, the State of Iowa is registering its commitment to accomplish the following goals:

- Rebalance the expenditures in long term care to provide improved access to home and community based services.
- Provide transition services necessary to assure consumers can successfully move from ICF/MRs to the least restrictive living environment of their choice.
- Strengthen the HCBS system with an array of services provided under Iowa's traditional MR waiver to assure the supports in place are sufficient to sustain all eligible individuals in the community of their choice.

The grant funding will be utilized to expand services beyond what is currently offered under the MR waiver, and to provide one-time services to individuals transitioning into the community from ICF/MRs. The demonstration will build on the success of the Real Choice Systems Transformation initiatives that are ongoing. Some of the improvements to the system will include:

- Expanding affordable and accessible housing opportunities. Iowa Finance Authority (IFA), a significant partner in this project, has already begun developing a web-based database of affordable and accessible housing in Iowa. The Housing Registry will assist consumers who are considering their housing options. Under MFP, Iowa Medicaid will partner with the IFA to promote expansion of the HCBS Rent Subsidy program which currently provides temporary assistance to people eligible for or receiving waiver services until they can access Section 8 or other housing assistance programs.
- Empowering consumers and families. IME will engage in targeted outreach to consumers, family members and guardians to provide them with information on the advantages of independent living. Participants in the demonstration will have access to the new Consumer Choices Option available under HCBS waivers, which provides consumers with control over individual budgets for unskilled services and other supports.
- Transition services coordination. ICF/MR residents will receive support from transition services coordinators with the training needed to address the complex process of transitioning into the community. The services of these specialists will be available to anyone wishing to transition out of ICF/MRs.

In addition to the overall impact on the long-term care service system in Iowa, the ultimate outcome at the close of the five year grant period will be the successful, sustained transition of 528 individuals from ICF/MR settings into integrated communities. The total proposed budget for this project $64,130,167.

Project Abstract

Connecticut is committed to rebalancing its long-term care system. With a pooled, flexible budget method in place, Connecticut plans to fully implement the principles of Money Follows the Person in partnership with stakeholders.

The lead agency for Connecticut's Money Follows the Person Rebalancing Demonstration (MFP) will be the Department of Social Services (DSS). The Medical Care Administration is housed within DSS as are multiple programs including administration for the Area Agency of the Aging (AAA) and the Independent Living Centers (ILC). Connecticut plans to of the MFP through a team approach involving almost all units of the DSS reflecting the high level of coordination and collaboration needed for successful implementation.

Connecticut has all of the essential components in place to implement a successful demonstration including a strong transition program, flexible funding, a rebalancing goal, quality management, strong involvement of stakeholders and an excellent foundation of HCBS. Our goal, however, through MFP is to enhance what already exists. Connecticut will address service gaps and provide broader choices for persons who would like to receive long-term care in the community.

Through the successful implementation of MFP, Connecticut plans to increase the current percentage of people receiving services in the community from 50% in 2006 to 58% by 2011. Connecticut also plans to have a stronger quality management system in place providing the needed evidence that people are receiving quality care. Consumer satisfaction surveys will provide the important documentation that people are not just living in the community, but that they are fully participating.

The total budget of $73,363,299 will be used to complete 700 successful transitions over the next 5 years. Connecticut will expand its existing Transition Program to include 20 transition coordinators by 2009. DSS will contract with ILCs and AAAs to offer transition services to those persons who are institutionalized. Connecticut has agreements in place with the State Housing Authority and with the Department of Economic and Community Development to address the barrier of housing. Letters of intent from all key partners are attached to this proposal.

CALIFORNIA COMMUNITY TRANSITIONS GRANT ABSTRACT

The California Community Transitions demonstration will bring together the state's resources to develop culturally competent and self-directed community-based living options for persons who have been institutionalized for longer then six months.

To achieve this, local entities will design comprehensive transition models most appropriate for addressing their community's long-term care needs. Local entities will establish and manage Community Transition Teams (CTTs) to support the transition process. The state will be responsible for reviewing competitive applications and ensuring compliance with all state and federal rules. The state will conduct strategic planning during the year-long pre-implementation phase, which will be followed by the phase-in of the CTTs and participant enrollment during the remainder of the demonstration.

As the single state Medicaid agency, the California Department of Health Services (CDHS) will act as the overall coordinator for policy and operational issues related to the demonstration. CDHS will work with various stakeholders including state departments, community-based organizations, institutional providers, and consumer groups to implement the demonstration with the greatest possible level of collaboration.

The California Community Transitions demonstration will seek to successfully transition 2,000 persons from up to 10 regions in the state back into the community at a total cost of $130,387,502 federal dollars over a five year period. Questions about the demonstration should be forwarded to Carol Freels or Paula Acosta at the California Department of Health Services, Office of Long Term Care (916) 440-7535.

ABSTRACT
Wisconsin Department of Health and Family Services
MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION

Wisconsin has a strong history of providing home and community-based long-term care to individuals who prefer to live in a community setting. The Money Follows the Person Demonstration provides additional resources to extend the opportunity home and community-based care to more individuals.

Wisconsin intends to rebalance its system through a managed long-term care strategy that ensures that the money "responds to the needs of the individual" in a comprehensive system rather than money having to be made to "follow the individual" in a fragmented system. Wisconsin's goal is to have a managed long-term care system in place within five years. While that is likely to occur regardless of participation in this demonstration, the enhanced federal matching funds provided through the demonstration will facilitate the achievement of that goal.

The Department of Health and Family Services requests a total of $56,282,998 in federal matching funds for activities under the demonstration. The funding request includes:

- $53,482,379 - funding at the enhanced rate for Qualified HCB Services;
- $2,159,857 - funding at the enhanced rate for HCB Demonstration Services; and
- $640,762 - funding at the 50% Medicaid administrative rate for staff and administration.

Over the five years of the demonstration, Wisconsin expects to transition 1,322 eligible individuals from nursing facilities, Intermediate Care Facilities for Persons with Mental Retardation and Institutions for Mental Disease (as covered by the State Plan). Wisconsin also intends to increase the amount of funding

in the home and community-based long term care system by 44% over that time period.